U.S. Department of Labor

Office of Administrative Law Judges
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Issue Date: 18 April 2007

Case No. 2005-BLA-5240

In the Matter of

T. E.,

Claimant,

v.

CONSOL OF KENTUCKY, INC.,

Employer,

and

ACORDIA EMPLOYERS SERVICE,

Carrier,

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,

Party-in-Interest.

APPEARANCES:[1]

Andrew Delph, Esq.
Wolfe, Williams & Rutherford
Norton, Virginia
For the Claimant

[1] The Director, Office of Workers' Compensation Programs, a party in this proceeding, was not present or represented by counsel at the hearing. By failing to appear at the hearing or participate in this case after referral to this office, the Director is deemed to have waived any issue which it could have raised at any stage prior to the close of this record. By referring this matter for hearing, the District Director is further deemed to have completed evidentiary development and adjudication as required by the regulations. 20 C.F.R. § 725.421.

Martin E. Hall, Esq.
Jackson Kelly, PLLC
Lexington, Kentucky
For the Employer

BEFORE: LARRY S. MERCK
Administrative Law Judge

DECISION AND ORDER - AWARD OF BENEFITS

This case arises from a claim for benefits under Title IV of the Federal Coal Mine Health and Safety Act of 1969, as amended by the Black Lung Benefits Act of 1977 ("Act"), 30 U.S.C. § 901 *et seq.*, and the regulations issued thereunder, located in Title 20 of the Code of Federal Regulations. Regulation section numbers mentioned in this Decision and Order refer to sections of that Title.

Claimant filed this application for benefits on November 10, 2003. (DX 2).[2] The District Director issued a Proposed Decision and Order denying benefits on August 30, 2004. (DX 33a, 34). On November 18, 2004, the District Director, Office of Workers' Compensation Programs, referred this case to the Office of Administrative Law Judges for a hearing. (DX 35, 40). A formal hearing in this matter was conducted on June 1, 2006, in Lexington, Kentucky, by the undersigned. All parties were afforded full opportunity to present evidence as provided in the Act and the regulations issued thereunder. The opinion which follows is based on all relevant evidence of record.

ISSUES[3]

The issues in this case are:

1. Whether Claimant has pneumoconiosis as defined in the Act and regulations;

[2] In this Decision and Order, "ALJ" refers to Administrative Law Judge's Exhibits, "DX" refers to Director's Exhibits, "EX" refers to Employer's Exhibits, "CX" refers to Claimant's Exhibits, and "TR" refers to the transcript of the hearing.

[3] At the hearing, Employer withdrew the following contested issues: 1) timeliness; 2) miner; 3) post-1969 employment; and 4) insurance. In addition, Employer and Claimant stipulated to at least twenty-five years of coal mine employment. Employer also maintains an issue for appellate purposes only. (TR 18-20).

2. Whether Claimant's pneumoconiosis arose out of coal mine employment;

3. Whether Claimant is totally disabled; and,

4. Whether Claimant's disability is due to pneumoconiosis.

(TR 18-20; DX 40).

Based upon a thorough analysis of the entire record in this case, with due consideration accorded to the arguments of the parties, applicable statutory provisions, regulations, and relevant case law, I hereby make the following:

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Background:

Claimant, T. E., was born on June 14, 1951. (DX 2). He has a seventh grade education. *Id.* He is married and he has no dependent children. (DX 2; TR 21, 28).

At the hearing, the parties stipulated to at least twenty-five years of coal mine employment. (TR 19). Claimant's last coal mine employment was with Consol of Kentucky, Inc., for seven years, ending in 2000. (TR 27; DX 2-4). As a miner, Claimant worked as a roof bolter for more than twenty years, and he also ran a scoop, shuttle car, and cutter for several years and worked on a coal tipple. (TR 20-21). He testified that he also helped out on a continuous miner. (TR 20-21; DX 3, 4). He stated that he was exposed to significant amounts of coal dust in the aforementioned jobs. (TR 23-24). In 2000, Claimant ceased coal mine employment due to back and knee injuries that he sustained in a car accident. (TR 27-28; DX 2). In 1992, Claimant received a State Black Lung settlement. (DX 8).

Dr. Smith treats Claimant for his breathing problems. (TR 24). Claimant is prescribed Advair and Albuterol to help with his breathing. (TR 25, 28). Claimant complains that his "breathing's not real good at all." (TR 24). He also has occasional difficulty sleeping due to his breathing. (TR 29-30).

Claimant testified that he began smoking when he was around sixteen to eighteen years old and that he quit smoking during the winter prior to the hearing. (TR 25-26, 30). He stated that he smoked between half a pack and a pack of cigarettes on-and-

off during that time, but quit altogether for about eight to ten years. When he began to smoke again, he smoked cigars. (TR 26). Dr. Wicker reported that Claimant smoked half a pack of cigarettes a day from the time that he was eighteen years old until he quit one year ago. (DX 11). In his medical report, dated May 24, 2005, Dr. Forehand noted that Claimant reported that he smoked half a pack of cigarettes for fifteen years. (CX 1). In his report, dated November 7, 2002, Dr. Sundaram reported that Claimant quit smoking a year prior to the examination, but he did not state at what rate Claimant used to smoke. (DX 27). Dr. Jarboe reported that Claimant started smoking cigarettes and small cigars when he was eighteen or nineteen years old. (DX 29). He also recorded that Claimant had "quit on and off over the years." *Id*. When he was smoking, Claimant would smoke about a pack of cigarettes or five or six small cigars a day. *Id.* Dr. Repsher recorded that Claimant reported that he smoked up to one-half a pack of cigarettes a day, quitting after ten years. However, he also reported that Claimant "restarted smoking several times." *Id.* Claimant also reported to Dr. Repsher that he smokes an occasional cigar, but he denies inhaling. *Id.* In his report, Dr. Repsher noted that Claimant's carboxyhemoglobin was "elevated at 5.7%, suggesting a current 1 1/2 pack per day cigarette smoking habit." *Id.* Because the evidence regarding Claimant's smoking history is inconsistent and somewhat contradictory, I am unable to determine his exact smoking history.

Length of Coal Mine Employment:

The duration of a coal miner's employment is relevant to the applicability of various statutory and regulatory presumptions. At the hearing, the parties stipulated to at least twenty-five years of coal mine employment. (TR 19). Based upon my full review of the record, I accept the stipulation and credit Claimant with at least twenty-five years of coal mine employment, as that term is defined by the Act and Regulations. (DX 2-4). He last worked in the Nation's coal mines in 2000. (DX 2).

Dependency:

On his application form, Claimant alleged one dependent for the purpose of benefit augmentation, namely his wife, W. J., whom he married on December 12, 1970. (TR 21; DX 2). Claimant's official marriage record was admitted into the record. (DX 9). Accordingly, I find that Claimant has one dependent for the purpose of benefit augmentation.

Applicable Regulations:

Claimant filed this claim on November 10, 2003. (DX 2). Because this claim was filed after March 31, 1980, the effective date of Part 718, it must be adjudicated under those regulations. In addition, the Amendments to the Part 718 regulations, which became effective on January 19, 2001, are also applicable.

The 2001 amendments significantly limit the development of medical evidence in black lung claims. The regulations provide that claimants are limited to submitting no more than two chest x-rays, two pulmonary function tests, two arterial blood gas studies, one autopsy report, one biopsy report of each biopsy, and two medical reports as affirmative proof of their entitlement to benefits under the Act. § 725.414(a)(2)(i). Any chest x-ray interpretations, pulmonary function test results, arterial blood gas study results, autopsy reports, biopsy reports and physician opinions that appear in a single medical report must comply individually with the evidentiary limitations. *Id.* In rebuttal to evidence propounded by an opposing party, a claimant may introduce no more than one physician's interpretation of each chest x-ray, pulmonary function test, arterial blood gas study, biopsy or autopsy. § 725.414(a)(2)(ii). Likewise, employers and the District Director are subject to similar limitations on affirmative and rebuttal evidence. § 725.414(a)(3).

Pneumoconiosis:

Section 718.202(a) sets forth four alternate methods for determining the existence of pneumoconiosis. Pursuant to § 718.202, the miner can demonstrate pneumoconiosis by means of 1) x-rays interpreted as positive for the disease, or 2) biopsy or autopsy evidence, or 3) the presumptions described in §§ 718.304, 718.305, or 718.306, if found to be applicable, or 4) a reasoned medical opinion which concludes the presence of the disease, if the opinion is based on objective medical evidence such as pulmonary function studies, arterial blood gas tests, physical examinations, and medical and work histories.

Under § 718.202(a)(1), a finding of the presence of pneumoconiosis may be based upon a chest x-ray conducted and classified in accordance with § 718.102. To establish the existence of pneumoconiosis, a chest x-ray must be classified as category 1, 2, 3, A, B, or C, according to the ILO-U/C

classification system. A chest x-ray classified as category 0, including subcategories 0/1, 0/0, or 0/-, does not constitute evidence of pneumoconiosis. Five x-rays have been designated as evidence by the parties in this case.

Dr. Wicker, a B-reader,[4] interpreted a December 5, 2003, x-ray as negative for pneumoconiosis.[5] (DX 11). Dr. Barrett, a Board-certified Radiologist and B-reader, re-read the x-ray for quality purposes only. (DX 12). Dr. Wiot, a Board-certified Radiologist and B-reader,[6] interpreted the December 5, 2003, x-ray as negative for pneumoconiosis.[7] (EX 2). Claimant offered no

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[4] A B-reader is a physician who has demonstrated proficiency in assessing and classifying x-ray evidence of pneumoconiosis by successful completion of an examination conducted by or on behalf of the United States Department of Health and Human Services. 42 C.F.R. § 37.51. The qualifications of physicians are a matter of public record at the National Institute for Occupational Safety and Health reviewing facility at Morgantown, West Virginia. Because B-readers are deemed to have more training and greater expertise in the area of x-ray interpretation for pneumoconiosis, their findings may be given more weight than those of other physicians. *Taylor v. Director, OWCP*, 9 B.L.R. 1-22 (1986).

[5] By Order dated March 13, 2007, Claimant was required to submit a Black Lung Benefits Act Evidence Summary Form designating the evidence that he intended to rely upon in this case. Claimant submitted an updated copy of this form on March 26, 2007, with no objections from Employer. Claimant's Evidence Summary Form is hereby admitted into evidence as CX 3.

[6] In its closing brief, Employer argues that because Dr. Wiot is both a Board-certified Radiologist and a C-reader, his x-ray interpretations should be given greater weight than those of the other physicians of record, who are Board-certified Radiologists and B-readers. However, Dr. Wiot's *curriculum vitae* states that he is a B-reader, and Employer did not submit any evidence to establish that he is a C-reader. Accordingly, Dr. Wiot's x-ray interpretations are given the same weight as those made by the other dually-qualified physicians who also interpreted Claimant's x-rays. Even if Dr. Wiot's x-ray interpretations had been given more weight, the outcome of this case would remain unchanged since Claimant fails to establish pneumoconiosis pursuant to § 718.202(a)(1).

[7] Employer designated Dr. Wiot's x-ray reading as rebuttal to the x-ray reading by Dr. Wicker, which was done as part of Claimant's Department of Labor ("DOL")-sponsored pulmonary evaluation. (CX 6; DX 9). In an unpublished decision, the Board held that "rebuttal" evidence need only refute "the case" presented by the opposing party rather than refute a particular piece of evidence. *Sprague v. Freeman United Coal Mining Co.*, BRB No. 05-1020 BLA (Aug. 31, 2006). In particular, the Board held that the Administrative Law Judge should have allowed Claimant's positive x-ray rereading to "rebut" a positive x-ray interpretation underlying the § 725.406 pulmonary evaluation. The Board reasoned that such evidence constituted "rebuttal", because it was "responsive" to "the case presented by the opposing party." *Id.* Accordingly, Dr. Wiot's positive reading is admissible as rebuttal to the DOL-sponsored x-ray interpretation of Dr. Wicker, although both physicians

rebuttal evidence for this x-ray. Therefore, I find the December 5, 2003, x-ray negative for pneumoconiosis.

Dr. Brandon, a Board-certified Radiologist and B-reader, interpreted a November 7, 2002, x-ray as positive for pneumoconiosis, with a 2/1 profusion. (DX 27). Dr. Wiot, a Board-certified Radiologist and B-reader, interpreted this x-ray as negative for pneumoconiosis. (EX 6).[8] Therefore, the evidence regarding this x-ray is in equipoise.

Dr. Alexander, a Board-certified Radiologist and B-reader, interpreted an x-ray, dated April 26, 2005, as positive for pneumoconiosis, with a 1/1 profusion. (CX 2). Dr. Wiot, also a Board-certified Radiologist and B-reader, interpreted the x-ray as negative for pneumoconiosis. (EX 4). Therefore, the evidence regarding this x-ray is in equipoise.

Dr. Jarboe, a B-reader, interpreted an x-ray, dated June 6, 2003, as negative for pneumoconiosis, with a 0/1 profusion. (DX 29). No rebuttal evidence was proffered by Claimant. Therefore, I find this x-ray negative for pneumoconiosis.

Dr. Repsher, a B-reader, interpreted an x-ray, dated November 10, 2004, as negative for pneumoconiosis. (EX 1). No rebuttal evidence was proffered by Claimant. Therefore, I find this x-ray negative for pneumoconiosis.

Under Part 718, where the x-ray evidence is in conflict, consideration shall be given to the readers' radiological qualifications. *Dixon v. North Camp Coal Co.*, 8 B.L.R. 1-344 (1985). Thus, it is within the discretion of the administrative law judge to assign weight to x-ray interpretations based on the readers' qualifications. *Goss v. Eastern Associated Coal Co.*, 7 B.L.R. 1-400 (1984); *Aimone v. Morrison Knudson Co.*, 8 B.L.R. 1-32 (1985) (granting great weight to a B-reader); *Roberts v. Bethlehem Mines Corp.*, 8 B.L.R. 1-211, 1-213 n. 5 (1985) (granting even greater weight to a Board-certified radiologist).

Additionally, it is within the discretion of the administrative law judge to defer to the numerical superiority of the x-ray interpretations. *Edmiston v. F & R Coal Co.*, 14

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interpreted the x-ray as negative for pneumoconiosis.

[8] Employer identified Dr. Wiot's re-reading of the November 7, 2002, x-ray as EX 8 on its Black Lung Benefits Act Evidence Summary Form; however, this x-ray interpretation was identified and admitted as EX 6 at the hearing. (TR 12).

B.L.R. 1-65 (1990). The United States Court of Appeals for the Sixth Circuit has confirmed that consideration of the numerical superiority of the x-ray interpretations, when examined in conjunction with the readers' qualifications, is a proper method of weighing x-ray evidence. *Stanton v. Norfolk & Western Railway Co.*, 65 F.3d 55 (6th Cir. 1995) (citing *Woodward v. Director, OWCP*, 991 F.2d 314 (6th Cir. 1993)).

Ultimately, I find that three x-rays are negative for pneumoconiosis, and the evidence pertaining to the other two x-rays of record is in equipoise. Accordingly, I find that Claimant has failed to establish the existence of pneumoconiosis pursuant to § 718.202(a)(1) by a preponderance of the evidence.

Pursuant to § 718.202(a)(2), a claimant may establish the existence of pneumoconiosis by biopsy or autopsy evidence. As no biopsy or autopsy evidence exists in the record, this section is inapplicable in this case.

Section 718.202(a)(3) provides that it shall be presumed that the miner is suffering from pneumoconiosis if the presumptions described in §§ 718.304, 718.305, or 718.306 are applicable. Section 718.304 is not applicable in this case because there is no evidence of complicated pneumoconiosis. Section 718.305 does not apply because it pertains only to claims that were filed before January 1, 1982. Finally, § 718.306 is not relevant because it is only applicable to claims of miners who died on or before March 1, 1978.

Under § 718.202(a)(4), the fourth and final method to establish pneumoconiosis, a determination of the disease may be made if a physician exercising reasoned medical judgment, notwithstanding a negative x-ray, finds that the miner suffers from pneumoconiosis as defined in § 718.201, which provides the following definition of pneumoconiosis:

> (a) For purposes of the Act, 'pneumoconiosis' means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. This definition includes both medical or "clinical" pneumoconiosis and statutory or "legal" pneumoconiosis.
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> (1) *Clinical Pneumoconiosis.* 'Clinical pneumoconiosis' consists of those diseases recognized by the medical community as

> pneumoconiosis, i.e., conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment. This definition includes, but is not limited to, coal workers' pneumoconiosis, anthra-cosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, silicosis or silicotuberculosis, arising out of coal mine employment.
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> (2) *Legal Pneumoconiosis*. 'Legal pneumoconiosis' includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. This definition includes, but is not limited to, any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment.
>
> (b) For purposes of this section, a disease 'arising out of coal mine employment' includes any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment.
>
> (c) For purposes of this definition, 'pneumoconiosis' is recognized as a latent and progressive disease which may first become detectable only after the cessation of coal mine dust exposure.

§ 718.201.

Any finding of pneumoconiosis under § 718.202(a)(4) must be based upon objective medical evidence and supported by a reasoned medical opinion. A reasoned medical opinion is one which contains underlying documentation adequate to support the physician's conclusions. *Field v. Island Creek Coal Co.*, 10 B.L.R. 1-19, 1-22 (1987). Proper documentation exists where the physician sets forth the clinical findings, observations, facts and other data on which he bases his diagnosis. *Id.*

Dr. Mitchell Wicker, Board-certified in Internal Medicine and a B-reader, examined Claimant on December 5, 2003. (DX 11). His complete medical workup included a chest x-ray, pulmonary function study, arterial blood gas analysis, and EKG. *Id.* Dr.

Wicker did not record exactly how many years Claimant worked in underground coal mine employment, but instead listed several overlapping and inconsistent date ranges that Claimant had worked for various coal companies, two of which were not specifically identified in his report. Dr. Wicker reported that Claimant began smoking at the age of fifteen, but quit smoking about a year earlier. He stated that during that period, Claimant smoked a half a pack of cigarettes a day. Dr. Wicker recorded that Claimant suffers from cough with large amounts of dark sputum production, and dyspnea on an uphill grade. A chest examination revealed the following abnormalities: "Increased A-P Diameter", under Inspection; "FINGER BREADTHS", under Percussion; and "Occasional Rhonchi", under Auscultation. *Id.* Claimant's EKG showed a "[s]inus rhythem (sic) at 72. PR interval .16. QRS .08. Poor R wave progression anteriorly possibly representing an old injury." *Id.* Under x-ray findings, Dr. Wicker stated that he saw no evidence of pneumoconiosis. Claimant's pulmonary function study was qualifying and his arterial blood gas analysis was non-qualifying.

In his report, Dr. Wicker did not list any cardiopulmonary diagnoses. Instead, he appeared to repeat the same statement that he had previously made under x-ray results, stating that he saw "no evidence of pneumoconiosis." *Id.* When prompted to discuss the etiology of any cardiopulmonary diagnoses, Dr. Wicker noted, "not applicable". *Id.* However, when discussing any impairment caused by Claimant's cardiopulmonary diagnosis, and the severity of any such impairment in terms of Claimant's ability to return to his current or last coal mine job of one year's duration, Dr. Wicker stated the following: "[t]his individual's respiratory capacity does not appear to be adequate to perform his duties in the coal mining industry due to cigarette abuse." *Id.* When prompted to explain the extent to which Claimant's cardiopulmonary diagnoses contribute to the disabling pulmonary impairment that he had found, Dr. Wicker again noted, "not applicable". *Id.*

A report may be given little weight where it is internally inconsistent and inadequately reasoned. *Mabe v. Bishop Coal Co.*, 9 B.L.R. 1-67 (1986). *See also Cranor v. Peabody Coal Co.*, 22 B.L.R. 1-1 (1999) (en banc on recon.) (the Board concluded that it was proper for the administrative law judge to give less weight to the report of Dr. Fino because his opinion was based upon a CT-scan which was not in the record and he did not have the benefit of reviewing the two most recent qualifying pulmonary function studies). In his medical report, Dr. Wicker did not diagnose any cardiopulmonary diseases or conditions, but

instead stated that he saw no evidence of pneumoconiosis. Although no diagnosis was given, Dr. Wicker opines that Claimant is totally disabled from a respiratory standpoint, which he attributed to cigarette abuse, with no mention of Claimant's lengthy history of coal dust exposure. However, Dr. Wicker also stated that no respiratory or pulmonary disease contributed to Claimant's impairment. In addition, Dr. Wicker gave no reasoning for his opinion and failed to cite the objective medical testing that he relied on in making his conclusions. Therefore, for these reasons, I find Dr. Wicker's medical report internally inconsistent and unreasoned, and I give it little weight.[9]

Dr. Raghu Sundaram, Board-certified in Internal Medicine, examined Claimant on November 7, 2002.[10] (DX 27). His complete medical workup included a chest x-ray, pulmonary function study, and an arterial blood gas analysis. Dr. Sundaram recorded that

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[9] The District Director is required to provide each miner applying for benefits with the "opportunity to undergo a complete pulmonary evaluation at no expense to the miner." § 725.406(a). A complete evaluation includes a report of the physical examination, a chest x-ray, a pulmonary function study, and an arterial blood gas study. Reviewing courts have added to this burden by requiring the pulmonary evaluation be sufficient to constitute an opportunity to substantiate a claim for benefits. *See Petry v. Director*, OWCP 14 B.L.R. 1-98, 1-100 (1990)(*en banc*); *see also Newman v. Director*, OWCP, 745 F.2d 1161 (8th Cir. 1984); *Prokes v. Mathews*, 559 F.2d 1057, 1063 (6th Cir. 1977).

In this Decision and Order, I have found that Dr. Wicker's opinion is unreasoned for purposes of determining pneumoconiosis as noted above. However, because Claimant has proven pneumoconiosis, by a preponderance of the evidence, pursuant to § 718.202(a)(4), without the benefit of Dr. Wicker's evaluation, I find that remand of this case for the completion of the DOL-sponsored complete pulmonary evaluation is unnecessary. *Larioni v. Director, OWCP*, 6 B.L.R. 1-1276 (1984); *see, e.g., Mullins v. Director, OWCP*, No. 05-0295 BLA (BRB, Jul. 27, 2005)(unpub.); *Bowling v. Director, OWCP,* No. 05-0327 BLA (BRB, Jul. 29, 2005)(unpub.).

[10] Employer submitted evidence that Dr. Sundaram was indicted for Medicare fraud on May 16, 2005. In *Boyd v. Clinchfield Coal Co.*, 46 F.3d 1122, 1995 WL 10226 (4th Cir. 1995) (table), the Fourth Circuit held that it was proper for the administrative law judge to take judicial notice of Dr. Vinod Modi's criminal conviction. Moreover, citing to *Adams v. Canada Coal Co.*, Case No. 91-3706 (6th Cir. July 13, 1992)(unpublished) (the administrative law judge "was obviously justified" in not crediting the testimony of Dr. Modi because of his conviction), the court upheld the administrative law judge's decision to accord no weight to Dr. Modi's medical opinion in light of his conviction for tax evasion. *See also Middlecreek Coal Co. v. Director, OWCP*, 91 F.3d 132 (4th Cir. 1996); *Matney v. Lynn Coal Co.*, 995 F.2d 1063 (4th Cir. 1993). In this case, although he was indicted, Dr. Sundaram has not been convicted of a crime. Accordingly, his indictment is irrelevant for the purpose of deciding this case.

Claimant worked in underground coal mining for thirty-three years. Dr. Sundaram did not record exactly how long or how much Claimant had smoked, but he did record that Claimant had quit smoking one year earlier. Dr. Sundaram reported that Claimant experiences shortness of breath after walking one block and after going up one flight of stairs. A chest examination revealed rhonchi and wheezing. Dr. Sundaram interpreted the chest x-ray as positive for pneumoconiosis, although Claimant did not designate Dr. Sundaram's x-ray reading as part of his affirmative evidence. Dr. Sundaram based his diagnosis on the results of his own interpretation of the November 7, 2002, x-ray. Claimant's pulmonary function study was qualifying before and after the administration of a bronchodilator, but the arterial blood gas analysis was non-qualifying. Dr. Sundaram diagnosed Claimant with "an occupational lung disease caused by his coal mine employment", and "coal workers' pneumoconiosis", which he determined met the definition of both clinical and legal pneumoconiosis. He based his diagnoses on a positive chest x-ray, a physical exam, a qualifying pulmonary function test, and Claimant's lengthy history of coal dust exposure. Dr. Sundaram determined that Claimant is unable to do his usual coal mine employment or comparable and gainful work in a dust free environment due to shortness of breath with limited activity. He based his total disability finding on Claimant's x-ray, physical exam, and qualifying pulmonary function test. He also opined that Claimant's totally disabling impairment was related to both coal mine employment and cigarette smoking, stating that it is "[d]ifficult to separate impairment from coal dust [verses] cigarette smoking." *Id.*

At the hearing, Employer's attorney argued that Dr. Sundaram's opinion should be given less probative weight because Claimant designated Dr. Brandon's re-reading of the November 7, 2002, x-ray, as one of his two x-rays in support of his affirmative case, pursuant to § 725.414(a)(2)(i), rather than Dr. Sundaram's original reading of that x-ray. (TR 9). Both Drs. Brandon and Sundaram interpreted the x-ray as positive for pneumoconiosis. (DX 27). Accordingly, Employer argues that Dr. Sundaram considered evidence outside the record in forming his opinion. In *Keener v. Peerless Eagle Coal Co.*, the Board emphasized that a medical opinion must be based on evidence that is "properly admitted" in a claim. *Keener v. Peerless Eagle Coal Co.*, ___ B.L.R. ___, BRB No. 05-1008 BLA (Jan. 26, 2007)(en banc). If a report is based on evidence not admitted in the claim, then the administrative law judge must "address the impact of Section 725.414(a)(2)(i), (a)(3)(i)." *Id.* The Board noted that the Administrative Law Judge has several options in

handling a report based, in part or in whole, on evidence not admitted in the claim such as excluding the report, redacting the objectionable content, asking the physician to submit a new report, or "factoring in the physician's reliance upon the inadmissible evidence when deciding the weight to which his opinion is entitled." *Id.* The Board specifically stated, however, that "exclusion is not a favored option, because it may result in the loss of probative evidence developed in compliance with the evidentiary limitations." *Id.* I find that Claimant has not shown good cause for exceeding the evidentiary limitations. However, Dr. Sundaram based Claimant's clinical and legal pneumoconiosis diagnoses on other objective evidence, besides his undesignated x-ray reading, including Claimant's work, medical, and smoking histories, a complete physical exam, and a qualifying pulmonary function test. Accordingly, having factored in his reliance on the x-ray reading, I find that Dr. Sundaram's limited reliance on his x-ray interpretation insufficient to justify discrediting or discounting his medical report.

In *Cornett v. Benham Coal, Inc.*, the Sixth Circuit held that a physician's opinion that the claimant's "obstructive ventilatory defect could have been caused by either smoking or coal dust exposure" should be viewed under the circumstances of that case as "tantamount to a finding that both coal dust exposure and smoking were operative factors and that it was impossible to allocate blame between them." *Cornett v. Benham Coal, Inc.*, 227 F.3d 569, 576 (6th Cir. 2000). The Court emphasized that such a finding was sufficient to establish that the claimant's pneumoconiosis arose out of his coal mine employment, stating that:

> [U]nder the statutory definition of pneumoconiosis, Cornett was not required to demonstrate that coal dust was the *only* cause of his current respiratory problems. He needed only show that he has a chronic respiratory and pulmonary impairment 'significantly related to, or substantially aggravated by, dust exposure in coal mine employment.'

Id. at 576 (citing 20 C.F.R. § 718.201)(emphasis in original).

The Court went on to find that the Administrative Law Judge improperly discounted the physicians' opinions, and emphasized that "accurately following the regulatory definition of pneumoconiosis cannot be grounds for rejecting a doctor's opinion." *Cornett v. Benham Coal, Inc.*, 227 F.3d 569, 576 (6th Cir. 2000).

Furthermore, in *Crockett Collieries, Inc. v. Barrett*, the Sixth Circuit affirmed an Administrative Law Judge's award of benefits. *Crockett Collieries, Inc. v. Barrett*, 478 F.3d 350 (6th Cir. 2007)(J. Rogers, concurring). In *Barrett*, both Drs. Baker and Dahhan concluded that the miner suffered from a respiratory impairment. *Id.* at 356. However, they disagreed as to whether the impairment "could all be due to cigarette smoking or could be due to a combination of cigarette smoking and coal dust exposure." *Id.* Dr. Baker concluded that coal dust exposure "probably contributes to some extent in an undefinable portion" to the miner's pulmonary impairment. *Id.* The Court agreed with the Administrative Law Judge's reasoning, holding that after invoking the rebuttable presumption that the miner's legal pneumoconiosis arose out of coal dust exposure at § 718.203(b), the Administrative Law Judge properly found Dr. Baker's opinion sufficient, and not too equivocal, to support a finding that the miner suffered from pneumoconiosis arising out of coal mine employment. *Id.* at 358; *see also Mountain Clay, Inc. v. Spivey*, 172 Fed. Appx. 641 (6th Cir. 2006)(unpub.)(holding that the Administrative Law Judge properly credited a physician's opinion, which stated that the claimant's pneumoconiosis was related to coal dust exposure, by considering other possible factors, such as smoking, age, obesity, or hypertension.).

In this case, Dr. Sundaram diagnosed clinical and legal pneumoconiosis, and found that Claimant's pneumoconiosis has been "significantly contributed to, or substantially aggravated by, dust exposure in coal mine employment", and cigarette smoking, but found it difficult to separate how much of Claimant's impairment was caused by each factor. (DX 27). In forming his opinion, Dr. Sundaram relied on Claimant's physical exam, chest x-ray, qualifying pulmonary function test, and his significant history of dust exposure. Therefore, because his opinion is based on objective medical evidence, as defined in § 718.201 to include medical testing and Claimant's medical and work histories, I find Dr. Sundaram's report well-reasoned and well-documented.

Dr. J. Randolph Forehand, Board-certified in Allergy and Immunology and Pediatrics and Board-eligible in Pediatric Pulmonary Medicine, conducted a physical examination on April 26, 2005. (CX 1). His complete medical workup included a chest x-ray, pulmonary function test, arterial blood gas study, and EKG. He recorded that Claimant worked in the coal mine industry for thirty-three years, including twenty-nine years as a roof bolter, two years as a cutting machine operator, and two years

as a scoop operator. Dr. Forehand reported that Claimant had smoked half a pack of cigarettes for fifteen years and now smokes one-half a pack of cigars a week. Dr. Forehand's report noted that Claimant suffered from "an eight-year history of progressively worsening breath on exertion with such activities as climbing a flight of stairs, walking uphill, lifting and carrying items around his house and when attempting to mow and garden his lawn." *Id.* Claimant also complained of exertional and nighttime wheezing requiring three pillows, and a cough accompanied by a sharp retrosternal chest pain. *Id.* Dr. Forehand reported that these symptoms occur daily on a perennial basis without seasonal variability and are made worse when Claimant is "exposed to smoke, fumes, dust or extremes of temperature and humidity." *Id.* A chest examination and EKG were essentially normal. Dr. Forehand interpreted the chest x-ray as positive. Claimant's pulmonary function tests produced qualifying results, both before and after bronchodilators were administered. A resting arterial blood analysis was qualifying, but the results were non-qualifying after exercise.

Dr. Forehand opined that Claimant suffers from a combination of coal workers' pneumoconiosis and cigarette smoker's lung disease. (CX 1). He based his opinion on the occupational history, personal/social history, physical examination, a positive x-ray, qualifying pulmonary function tests, both before and after the administration of a bronchodilator, and a resting arterial blood gas study that was qualifying. Dr. Forehand opined that Claimant has a totally and permanently disabling respiratory impairment, which is brought on by the combination of coal dust exposure for thirty-three years and smoking a half a pack of cigarettes a day for fifteen years. Dr. Forehand further explained that twenty-nine years of exposure to silica dust is a more important factor contributing to Claimant's respiratory impairment than his seven and a half pack-year history of smoking cigarettes, as Claimant's smoking history alone is insufficient to cause a respiratory impairment as severe as Claimant's respiratory impairment.

Dr. Forehand's x-ray reading is not designated as part of Claimant's affirmative evidence, as Dr. Alexander's re-reading was submitted by Claimant as part of his affirmative evidence, pursuant to § 725.414(a)(2)(i). Drs. Alexander and Forehand both read the x-ray as positive for pneumoconiosis. I find that Claimant has not shown good cause for exceeding the evidentiary limitations set out in § 725.414(a)(2)(i); however, considering Dr. Forehand's limited reliance on the x-ray results, and the Board's holding that "exclusion is not a favored option," it is

appropriate in this case to factor in Dr. Forehand's reliance upon his own x-ray reading when deciding the weight to which his opinion is entitled. *Keener v. Peerless Eagle Coal Co.*, ___ B.L.R. ___, BRB No. 05-1008 BLA (Jan. 26, 2007)(en banc). Accordingly, because Dr. Forehand based his clinical and legal pneumoconiosis diagnoses on other objective evidence, besides his x-ray reading, including Claimant's work, medical, and smoking histories, a complete physical exam, qualifying pulmonary function tests, and a qualifying resting arterial blood gas study, I find that Dr. Forehand's limited reliance on his x-ray reading is insufficient to justify discrediting or discounting his report.

Dr. Forehand's opinion regarding Claimant's pneumoconiosis is supported by the results of his own objective medical testing, as well as much of the objective testing conducted by the other physicians of record. Additionally, Dr. Forehand's reasoning accounts for Claimant's significant coal dust exposure, without ignoring his smoking history. Furthermore, because all of the physicians of record diagnosed a chronic obstructive lung disease, and I have found that Claimant had at least twenty-five years of coal mine employment, Dr. Forehand's opinion that Claimant's pneumoconiosis is related to his coal mine employment is consistent with the presumption that pneumoconiosis in a coal miner who worked ten years or more in the mines arose out of his or her coal mine employment. § 718.203(b); *Crockett Collieries, Inc. v. Barrett*, 478 F.3d 350 (6th Cir. 2007)(J. Rogers, concurring). Accordingly, I find Dr. Forehand's opinion regarding pneumoconiosis well-reasoned and well-documented.

Dr. Lawrence Repsher, Board-certified in Internal Medicine with a Sub-specialty in Pulmonary Disease and a B-reader, conducted a physical examination of Claimant on November 10, 2004. (EX 1). Dr. Repsher ordered a chest x-ray, pulmonary function test, arterial blood gas study, and EKG. He recorded that Claimant worked in underground coal mine employment for thirty-three years, until 2000. Dr. Repsher noted that Claimant reported that he smoked up to one-half a pack of cigarettes a day since age seventeen or eighteen, quitting after ten years. He also reported that Claimant has restarted smoking several times, and still smokes an occasional cigar, although he denies that he inhales. Dr. Repsher noted that Claimant complains of progressive dyspnea on exertion for the past five to six years, as well as an occasional cough with sputum production. Claimant also complains of trouble sleeping because of his breathing problems. A chest examination was normal and an EKG showed "a

healed anterior [myocardial infarction]." *Id.* Dr. Repsher determined that Claimant's pulmonary function study, which produced qualifying values both before and after the administration of a bronchodilator, revealed "extremely severe COPD (chronic obstructive pulmonary disease) with severe impairment of the DLCO (diffusing capacity of the lung for carbon monoxide), indicating severe underlying emphysema." *Id.* The arterial blood gas analysis showed mild hypoxemia, but the results were non-qualifying. Dr. Repsher interpreted Claimant's chest x-ray as negative for pneumoconiosis.

Dr. Repsher diagnosed Claimant with severe COPD, but opined that it was "due to a long, heavy and continued cigarette smoking habit." (EX 1). He also diagnosed chronic cervical back pain, due to an injury sustained in a motor vehicle accident. Dr. Repsher opined that Claimant "does not now and never has had coal workers pneumoconiosis or any other pulmonary or respiratory disease or condition, either caused by or aggravated by his employment as a coal miner for the Consol of Kentucky with exposure to coal mine dust." *Id.* In coming to this conclusion, Dr. Repsher relied on the following reasoning:

1. [Claimant] has no radiographic evidence of CWP (coal workers' pneumoconiosis).

2. [Claimant] has no lung biopsy tissue evidence of CWP.

3. [Claimant] has no pulmonary function test evidence of CWP. His pulmonary function tests show pure COPD. Coal workers' pneumoconiosis, when clinically significant, is primarily a restrictive disease that may have some obstructive features. It would be most atypical for CWP to manifest as a pure obstructive pulmonary impairment.

4. [Claimant] has no arterial blood gas evidence of CWP. His mild and nonqualifying hypoxemia is more than adequately accounted for by his underlying severe COPD and emphysema.

5. He is suffering from a number of serious and potentially serious diseases and conditions. However, none of these could be fairly attributed to his work as a coal miner with exposure to coal mine dust. Rather, these are diseases and conditions of

> the general population, which are primarily related to heredity and lifestyle factors.

(EX 1).

Dr. Repsher testified by deposition on April 27, 2006. (EX 5). He reviewed all of the medical evidence that was designated by Claimant and Employer, in addition to the interpretation of a February 16, 2006, x-ray by Dr. Deponte, which exceeds the evidentiary limitations and is not designated by either party or admitted into the evidentiary record. *Id.* Dr. Repsher asserted that Claimant "minimized" his smoking history when reporting it to the physicians who had conducted his examinations in preparation for litigation of his claim for benefits. *Id.* He stated that the "carboxyhemoglobin tests and serum nicotine and cotinine levels that [he] obtained," and the carboxyhemoglobin test obtained by Dr. Jarboe, show that Claimant was smoking between a pack and a pack and a half of cigarettes a day during the period that he was examined by both physicians. *Id.* Claimant reported that he only smoked an occasional cigar at the time, and that he had never smoked more than half a pack of cigarettes a day, statements, which Dr. Repsher alleged "are clearly not true." *Id.* Although on cross-examination, he admitted that some of the biochemical testing could have been affected if Claimant had smoked a cigar shortly before he was examined. *Id.* In his deposition, Dr. Repsher continued to diagnose severe COPD. Additionally, he testified that Claimant's pulmonary function tests revealed severe COPD "probably with no significant bronchodilator response." *Id.* He also stated that while the pulmonary function tests obtained by Dr. Jarboe would suggest there is a reversible component, he believed the improvement was "more apparent than real." *Id.* Dr. Repsher continued to believe that Claimant could not perform his previous job as a roof bolter in a coal mine. *Id.*

In his deposition, Dr. Repsher rebutted several of the underlying tests performed by Claimant's physicians, including the x-ray readings done by Drs. Alexander, Brandon, and Deponte, all of which are Board-certified Radiologists and B-readers, stating that he doesn't consider any of these dually-qualified physicians "to be reliable B-readers." *Id.* He also rejected Dr. Forehand's medical opinion, by stating that "he clearly has not read the literature to anywhere near the extent that I have because he has a completely erroneous concept of the coal mine literature with regard to COPD and coal mining." *Id.* Dr. Repsher also testified that he believes that "it is statistically certain, but it would be very uncommon," for coal

mine dust inhalation to cause a purely obstructive disabling respiratory impairment absent x-ray evidence of clinical pneumoconiosis. *Id.* When asked to explain why Claimant is not part of the statistically uncommon group of coal miners who have COPD as a result of coal dust exposure, Dr. Repsher stated, "[b]ecause it would be statistically extraordinarily unlikely..." *Id.* In addition, Dr. Repsher agreed that those individuals who are at that extreme end of the spectrum, where they would be susceptible enough to coal dust to contract COPD, would not be diagnosed as being at that extreme end of the spectrum simply because it is statistically unlikely, although possible. When asked if a person can have coal workers' pneumoconiosis without x-ray evidence of it, Dr. Repsher answered affirmatively, and went on to state the following:

> In fact, it's probably more common than not. I would clearly concede that if you were to biopsy Mr. [E.'s] lung or do an autopsy, that it would be more likely than not that he would probably have histologic coal workers' pneumoconiosis.

(EX 5).

Claimant's attorney also asked Dr. Repsher if, in his opinion, Claimant has both COPD and coal worker's pneumoconiosis; to which Dr. Repsher replied:

> Well, I can't state to a certainty he has coal worker's pneumoconiosis, but I think more likely than not he does have histologic coal worker's pneumoconiosis, but we don't know that unless we get a lung biopsy or an autopsy.

(EX 5).

Claimant's attorney followed up on Dr. Repsher's response, asking Dr. Repsher whether his indication that it was more likely than not that Claimant has coal worker's pneumoconiosis was a statistical probability, since his opinion about the cause of Claimant's disabling COPD was also based on a statistic. Dr. Repsher replied, "[y]es, based on my own personal experience." (EX 5).

The regulations provide that "[t]he testimony of any physician which is taken by deposition shall be subject to the limitations on the scope of testimony contained in § 725.457(d)." § 725.458. Section 725.457(d) provides that "[a]

physician whose testimony is permitted under this section may testify as to any other medical evidence of record, but shall not be permitted to testify as to any medical evidence relevant to the miner's condition that is not admissible." § 725.457(d). Furthermore, in response to the public comments on the 2001 amendments to the regulations, the Department noted that inclusion of subsection (d) was necessary to ensure the parties' adherence to the evidentiary limitations. Regulations Implementing the Federal Coal Mine Health and Safety Act of 1969, 65 Fed. Reg. 80,002 (Dec. 20, 2000). In his deposition testimony, Dr. Repsher reviewed and addressed Dr. Deponte's x-ray interpretation, which was not admitted in the record. Although Dr. Repsher reviewed medical evidence that is not included anywhere in the record, and which also exceeds the evidentiary limitations contained in § 725.414, I find that his reliance on this evidence is minimal and do not discount his deposition testimony and medical report for this reason.

In his report, Dr. Repsher determined that Claimant does not have clinical pneumoconiosis because he found no radiographic evidence of the disease. (EX 1). In an unpublished opinion in *Mountain Clay, Inc., v. Spivey*, the Sixth Circuit affirmed the Board's decision, which had affirmed the Administrative Law Judge's award of benefits. *Mountain Clay, Inc., v. Spivey*, 172 Fed.Appx. 641, 645 (6th Cir. 2006). The Court held that Dr. Chandler's and Dr. Broudy's opinions could be discounted because each physician had based his opinion that the claimant's pulmonary impairment was not due to pneumoconiosis on the negative x-ray evidence. *Id.* The Court cited to *Cornett* for the proposition that restatement of x-ray results does not constitute reasoned medical judgment, and to the regulations, which declare that "[n]o claim for benefits shall be denied solely on the basis of a negative chest X-ray." § 718.202(b). Accordingly, because Dr. Repsher's opinion that Claimant does not have clinical pneumoconiosis is based solely on his negative x-ray interpretation, his opinion serves as a restatement of the x-ray results, and is not well-reasoned or well-documented.

In addition, Dr. Repsher disregarded the positive x-ray readings made by Dr. Alexander and Dr. Brandon, even though both physicians are Board-certified Radiologists and B-readers. Accordingly, their x-ray interpretations are entitled to receive more weight than a reading of the same x-ray made by Dr. Repsher, who is a B-reader. In considering all of the evidence of record, Dr. Repsher's failure to adequately consider the opinions of physicians who are better qualified to interpret

chest x-rays for pneumoconiosis is a valid reason for discounting Dr. Repsher's opinion in this case, because his opinion is not based on a complete picture of Claimant's condition.

In addition, Dr. Repsher does not consider whether Claimant's pulmonary disease was contributed to, or aggravated by, his exposure to coal dust. Instead, Dr. Repsher only considers whether one or the other caused Claimant's chronic respiratory disease. In *Cornett v. Benham Coal, Inc.*, the Sixth Circuit rejected this analysis, holding that a determination that coal dust exposure did not contribute to or aggravate the claimant's respiratory problems should require an explanation by the physician as to why coal mine employment was eliminated as a possible cause. *Cornett v. Benham Coal, Inc.*, 227 F.3d 569, 576 (6th Cir. 2000). Dr. Repsher's statement that his determination regarding his diagnoses and causation were based solely on statistical probability do not amount to a reasoned explanation.

Moreover, in *Crockett Collieries, Inc., v. Barrett*, the Sixth Circuit noted that the Administrative Law Judge had properly invoked the presumption of causation contained in § 718.203(b) because the claimant had worked in coal mine employment for more than ten years. *Crockett Collieries, Inc., v. Barrett*, 478 F.3d 350, 355 (6th Cir. 2007). The presumption of causation is also invoked in this case, as I have credited Claimant with at least twenty-five years of coal mine employment, which was stipulated to by both parties at the hearing. Therefore, Claimant is entitled to the presumption that his COPD, or legal pneumoconiosis, arose out of his coal mine employment.

Furthermore, an opinion may be given little weight if it is equivocal or vague. *Island Creek Coal Co. v. Holdman*, 202 F.3d 873 (6th Cir. 2000) (a physician, who concluded that simple pneumoconiosis "probably" would not disrupt a miner's pulmonary function, was equivocal and insufficient to "rule out" causal nexus as required by § 727.203(b)(3)); *Griffith v. Director, OWCP*, 49 F.3d 184 (6th Cir. 1995) (treating physician's opinion entitled to little weight where he concluded that the miner "probably" had black lung disease); *Justice v. Island Creek Coal Co.*, 11 B.L.R. 1-91 (1988) (an equivocal opinion regarding etiology may be given less weight); *Parsons v. Black Diamond Coal Co.*, 7 B.L.R. 1-236 (1984) (equivocal regarding disability); *Amax Coal Co. v. Director, OWCP [Chubb]*, 312 F.3d 882 (7th Cir. 2002) (under Part 727, the administrative law judge properly discredited the opinion of Dr. Meyers as too

equivocal because he found that the miner suffered from a "significant limitation," but "it appeared more cardiac than pulmonary"). Based on the evidence discussed in detail above, I find Dr. Repsher's opinion regarding whether or not Claimant has pneumoconiosis to be equivocal and vague. Clear inconsistencies exist between the unwavering assertions contained in Dr. Repsher's medical report—in which he declared that Claimant does not have, and never has had pneumoconiosis and that Claimant's COPD was not caused by coal dust exposure—and statements made during his deposition, when he stated that his diagnoses of Claimant's condition and his assertions regarding causation were based on statistical probability, and not on Claimant's actual condition. (EX 1, 5). Furthermore, Dr. Repsher's statement that he thought, "more likely than not [Claimant] does have histologic coal worker's pneumoconiosis," reflects that Dr. Repsher's opinion is equivocal. Accordingly, I find that Dr. Repsher's opinion is entitled to little weight.

In sum, any of the reasons discussed in detail above would be sufficient to discount Dr. Repsher's opinion in this case. However, I rely on all of the foregoing reasons to find that Dr. Repsher's opinion neither well-reasoned nor well-documented.

Dr. Thomas Jarboe, Board-certified in Internal Medicine, with a Sub-specialty in Pulmonary Disease, and a B-reader, conducted Claimant's medical examination on May 18, 2004, and testified at the hearing on June 1, 2006. (DX 29; TR 33-74). His complete medical workup included a chest x-ray, pulmonary function test, and arterial blood gas study. In his medical report, Dr. Jarboe recorded that Claimant worked in underground coal mine employment for thirty-three years. (DX 29). He recorded that Claimant started smoking at the age of eighteen or nineteen, and has quit on and off over the years. He recorded that Claimant smoked a pack of cigarettes a day, when he smoked cigarettes. Claimant now smokes about five or six small cigars a day. Claimant reported that he believes that his entire smoking history spanned about eight years, when added together. Dr. Jarboe's report noted that Claimant suffers from shortness of breath, as he cannot walk more than fifty yards on level ground or up a flight of stairs without becoming winded. He has been dyspneic for the last ten to twelve years, but his condition has worsened in the last five years. Claimant also has a daily cough with sputum production. Claimant also suffers from wheezing, especially when lying flat on his right side or sitting in a certain position in a chair, as well as when the humidity is high. In addition, Dr. Jarboe reported that Claimant had surgery to repair a superficial stab wound when he was thirty-four years

old. (DX 29). Dr. Jarboe interpreted Claimant's x-ray as negative for pneumoconiosis, with a 0/1 profusion. His pulmonary function studies were non-qualifying before the administration of a bronchodilator, but showed some improvement after administration of the drug. However, the post-bronchodilator results were still qualifying, demonstrating residual disability. The arterial blood gas analysis was non-qualifying, but revealed mild hypoxemia.

Dr. Jarboe opined that Claimant does not have clinical or legal pneumoconiosis or any other disease arising out of coal dust exposure. (DX 29). Instead, Dr. Jarboe diagnosed Claimant with chronic bronchitis, bronchial asthma, and pulmonary emphysema, which he related to cigarette smoking and bronchial asthma. Dr. Jarboe's opinion that Claimant does not have clinical pneumoconiosis is based on a negative x-ray reading. Dr. Jarboe based his opinion regarding the cause of Claimant's chronic lung disease, or legal pneumoconiosis, on Claimant's responsiveness to bronchodilators, which were administered as part of the pulmonary function study. In addition, Dr. Jarboe noted that the arterial blood gas analysis revealed mild hypoxemia, but the results were non-qualifying. Dr. Jarboe concluded that he does not feel there is "sufficient medical evidence to justify a diagnosis of coal worker's pneumoconiosis..." (DX 29).

Dr. Jarboe opined that Claimant did not retain the physiological capacity to continue his previous coal mining work or a job of comparable physical demand because of his obstructive airway disease, which was caused entirely by a combination of cigarette smoking and bronchial asthma. (DX 29). He opined that Claimant's condition is not caused by or related to the inhalation of coal dust or coal workers' pneumoconiosis. *Id.* Dr. Jarboe explained his reasoning as follows:

> [Claimant] has very severe airflow obstruction but a demonstrated, marked response to bronchodilating agents. This would indicate a diagnosis of bronchial asthma. Coal dust inhalation causes a fixed, not a reversible effect.

(DX 29).

Dr. Jarboe also opined that the marked hyperinflation of the lungs, which was revealed by Claimant's x-ray, is nearly always associated with asthma or cigarette smoking, or a combination thereof. He further opined that if the

hyperinflation had been caused by coal dust exposure, there would have been more coal dust deposition visible on Claimant's chest x-ray. Dr. Jarboe concluded that Claimant is totally disabled and cannot return to his previous work as a coal miner. However, he relates Claimant's totally disabling impairment to a "combination of bronchial asthma and tobacco abuse." (DX 29). Dr. Jarboe also notes that his examination revealed an elevated carboxyhemoglobin level, consistent with a current smoking habit of one pack of cigarettes a day, although Claimant reported that he smoked only a few small cigars a day and had only smoked for eight years. *Id.*

In his hearing testimony, Dr. Jarboe stated that he had reviewed the reports of the other physicians of record. (TR 36-37). He stated that after reviewing all of the evidence, his opinion had not changed. He continued to opine that Claimant suffers from a disabling respiratory impairment that was caused by a combination of asthma and cigarette smoking, and not coal dust exposure. (TR 46). He based his opinion on results from the x-ray showing hyperinflation of Claimant's lungs, and Claimant's responsiveness to the administration of bronchodilators during his pulmonary function testing. *Id.*

During his testimony at the hearing, Dr. Jarboe demonstrated how an x-ray is read to determine whether pneumoconiosis is present. (TR 47-52).

When asked to restate the reasoning that he employed to find that Claimant does not have clinical or legal pneumoconiosis, as those terms are defined in § 718.201, Dr. Jarboe stated the following:

> [Claimant] has marked hyperinflation in the absence of dust retention, that he has a severely reduced diffusion capacity which is very uncommon in coal miners, in fact, not seen, that he has a very significant reversible component that is not seen in dust induced lung disease. So those findings, I think argue for causation by something else, other than the inhalation of coal dust.

(TR 54).

On cross-examination, Dr. Jarboe stated that coal dust exposure can cause emphysema and that he has diagnosed Claimant with emphysema. (TR 58). He also testified that while his diagnosis of asthma was based on the reversibility in Claimant's

pulmonary function studies, Claimant's results did not raise above the federal standard for determining total disability after the bronchodilator was administered. *Id.* He also stated that the residual disability demonstrated that a portion of Claimant's obstructive impairment was not reversible. In addition, Dr. Jarboe testified that coal mine dust inhalation could cause a purely obstructive impairment, absent x-ray evidence of coal worker's pneumoconiosis. (TR 58-59). Dr. Jarboe also testified that he is uncertain as to how much of an increase in hypoxyhemoglobin levels would result from Claimant's cigar smoking, as compared to cigarette smoking. (TR 60). When asked whether there was any reason not to treat the reversible portion of a patient's pulmonary impairment when that person suffers from both a reversible and nonreversible pulmonary impairment simultaneously, Dr. Jarboe answered no. (TR 61). Accordingly, Dr. Jarboe agreed that the use of the drug Advair, which Claimant uses for his breathing problems, really does not indicate anything about the irreversible part of the impairment. *Id.* In addition, Dr. Jarboe testified that some studies have shown that traditional x-rays have sometimes missed pneumoconiosis, even complicated pneumoconiosis, that was later discovered during an autopsy. (TR 63). Dr. Jarboe testified that while Claimant's impairment is caused by asthma, his asthma is aggravated by exposure to dust. (TR 64). He also stated that dust exposure could speed the development of obstruction in a person with bronchial hyper responsiveness. (TR 66). Finally, Dr. Jarboe testified that it is accepted that pneumoconiosis can be a progressive disease, but that it is also fixed, and does not improve. In explaining these theories, he stated that someone with a negative x-ray, who had worked thirty-years in the mines, would have dust scattered in their lungs, although no one has proven that the dust is causing progressive impairment. (TR 72).

Dr. Jarboe's finding that Claimant does not have clinical pneumoconiosis is based on his negative x-ray interpretation. As discussed above, the Sixth Circuit has held that this basis does not constitute reasoned medical judgment. *Mountain Clay, Inc., v. Spivey*, 172 Fed.Appx. 641, 645 (6th Cir. 2006)(citing *Cornett v. Benham Coal, Inc.*, 227 F.3d 569, 576 (6th Cir. 2000). Therefore, I find that Dr. Jarboe's opinion regarding clinical pneumoconiosis not well-reasoned or well-documented.

In addition, Dr. Jarboe diagnosed several other chronic respiratory conditions that meet the regulatory definition of legal pneumoconiosis, as discussed above, although Dr. Jarboe opined that reversibility of Claimant's pulmonary function

results post-bronchodilator demonstrated that coal dust exposure did not cause Claimant's respiratory problems. In *Consolidation Coal Co. v. Swiger*, the Fourth Circuit Court of Appeals upheld an Administrative Law Judge's finding that the reversibility of pulmonary function values after use of a bronchodilator does not preclude the presence of disabling coal workers' pneumoconiosis. *Consolidation Coal Co. v. Swiger*, Case No. 03-1971 (4th Cir. May 11, 2004) (unpub.). In particular, the Court noted the following:

> All the experts agree that pneumoconiosis is a fixed condition and therefore any lung impairment caused by coal dust would not be susceptible to bronchodilator therapy. In this case, although Swiger's condition improved when given a bronchodilator, the fact that he experienced a disabling residual impairment suggested that a combination of factors was causing his pulmonary condition. As a trier of fact, the ALJ 'must evaluate the evidence, weigh it, and draw his own conclusions.' (citation omitted). Therefore, the ALJ could rightfully conclude that the presence of the residual fully disabling impairment suggested that coal mine dust was a contributing cause of Swiger's condition. (citation omitted).

Id.

In this case, Dr. Jarboe expressly relied on the improvement in Claimant's pulmonary function results after the administration of a bronchodilator in determining that Claimant's impairment is caused by a combination of tobacco abuse and asthma. He also acknowledged that dust exposure could aggravate both asthma and emphysema, and that Claimant's post-bronchodilator pulmonary function test still produced qualifying results, which demonstrates that a portion of Claimant's impairment is irreversible. Accordingly, I find that Dr. Jarboe does not adequately address or explain why Claimant's significant history of coal dust exposure has not exacerbated respiratory diseases.

In addition, in *Cannelton Industries, Inc. v. Frye*, the Fourth Circuit concluded that the administrative law judge properly accorded less weight to the opinion of Dr. Forehand, who found that the miner was totally disabled due to smoking-induced bronchitis, but failed to explain "how he eliminated (the miner's) nearly thirty years of exposure to coal mine dust as a possible cause" of the bronchitis. In affirming the

administrative law judge, the court noted that "Dr. Forehand erred by assuming that the negative x-rays (underlying his opinion) necessarily ruled out that (the miner's) bronchitis was caused by coal mine dust ...." *Cannelton Industries, Inc. v. Frye*, Case No. 03-1232 (4th Cir. Apr. 5, 2004)(unpub.).

Moreover, in *Crockett Collieries, Inc. v. Barrett*, the Sixth Circuit agreed with the Administrative Law Judge's weighing of the medical evidence and affirmed the claimant's award of benefits, noting that:

> In rejecting Dr. Dahhan's opinion, the ALJ found that Dahhan had not adequately explained why Barrett's responsiveness to treatment with bronchodilators necessarily eliminated a finding of legal pneumoconiosis, and had not adequately explained 'why he believes that coal dust exposure did not exacerbate (the miner's) allegedly smoking-related impairments.'

Crockett Collieries, Inc. v. Barrett, 478 F.3d 350, 358 (6th Cir. 2007)(J. Rogers, concurring); *see also Mountain Clay, Inc. v. Spivey*, 172 Fed. Appx. 641 (6th Cir. 2006)(unpub.).

In this case, Dr. Jarboe failed to sufficiently explain the significance of Claimant's responsiveness to bronchodilators, particularly because Claimant's improved results are still qualifying under the regulations. Additionally, he did not adequately explain why he believes that coal dust exposure did not contribute to Claimant's impairment. Instead he chose to rely solely on his smoking history and evidence of asthma and emphysema, seemingly without truly considering whether coal dust exposure had a concurrent contributory effect on Claimant's respiratory condition. For the reasons stated above, Dr. Jarboe's opinion regarding legal pneumoconiosis is insufficiently reasoned. Therefore, I grant his opinion little probative weight on the issue of legal pneumoconiosis.

Thus, Claimant has established the existence of legal pneumoconiosis by a preponderance of the evidence pursuant to § 718.201(a)(4). In making this determination, I rely on the well-reasoned and well-documented reports of Drs. Forehand and Sundaram. In sum, I find that Claimant has not established pneumoconiosis pursuant to §§ 718.202(a)(1-3). However, Claimant has established pneumoconiosis pursuant to § 718.202(a)(4).

Causal Relationship Between Pneumoconiosis and Coal Mine Employment:

The Act and the regulations provide for a rebuttable presumption that pneumoconiosis arose out of coal mine employment if a miner with pneumoconiosis was employed in the mines for ten or more years. 30 U.S.C. § 921(c)(1); § 718.203(b). Based on the evidence of record, Claimant has established legal pneumoconiosis and that he worked in the coal mines for at least twenty-five years. As Employer's evidence is insufficient to rebut the presumption, Claimant has established that his pneumoconiosis arose out of his coal mine employment.

Total Disability:

Total disability is defined as Claimant's inability, due to a pulmonary or respiratory impairment, to perform his or her usual coal mine work or engage in comparable gainful work in the immediate area of the Claimant's residence. § 718.204(b). Total disability can be established pursuant to one of the four standards in § 718.204(b)(2) or the irrebuttable presumption of § 718.304, which is incorporated into § 718.204(b). The presumption is not invoked here because there is no x-ray evidence of large opacities classified as category A, B, or C, and no biopsy or equivalent evidence.

Where the presumption does not apply, a Claimant shall be considered totally disabled if he meets the criteria set forth in § 718.204(b)(2), in the absence of contrary probative evidence. The Board has held that under § 718.204(c), the precursor to § 718.204(b)(2), that all relevant probative evidence, both like and unlike, must be weighed together, regardless of the category or type, to determine whether a miner is totally disabled. *Shedlock v. Bethlehem Mines Corp.*, 9 B.L.R. 1-195, 1-198 (1986); *Rafferty v. Jones & Laughlin Steel Corp.*, 9 B.L.R. 1-231, 1-232 (1987). Furthermore, the Claimant must establish this element by a preponderance of the evidence. *Gee v. W.G. Moore & Sons*, 9 B.L.R. 1-4, 1-6 (1986).

Subsection (b)(2)(i) of § 718.204 provides for a finding of total disability where pulmonary function tests demonstrate FEV_1[11] values less than or equal to the values specified in the Appendix to Part 718 and such tests reveal FVC[12] or MVV[13] values

[11] Forced expiratory volume in one second.

[12] Forced vital capacity.

equal to or less than the applicable table values. Alternatively, a qualifying FEV_1 reading together with an FEV_1/FVC ratio of 55% or less may be sufficient to prove disabling respiratory impairment under this subsection of the regulations. § 718.204(b)(2) and Appendix B. The record consists of five pulmonary function studies, a pre-bronchodilator test conducted on November 7, 2002, and pre- and post-bronchodilator tests conducted on December 5, 2003, May 18, 2004, November 10, 2004, and April 26, 2005.[14] (DX 11, 27, 29; CX 1; EX 1).

All of Claimant's pulmonary function studies produced qualifying results, both before and after the administration of bronchodilators.[15] Therefore, I find that Claimant has established total disability by a preponderance of the evidence under subsection (b)(2)(i).

Section 718.204(b)(2)(ii) provides for the establishment of total disability through the results of arterial blood gas tests. Blood gas tests may establish total disability where the results demonstrate a disproportionate ratio of pCO_2 to pO_2, which indicates the presence of a totally disabling impairment in the transfer of oxygen from Claimant's lung alveoli to his blood. § 718.204(c)(2) and Appendix C. The test results must meet or fall below the table values set forth in Appendix C following Section 718 of the regulations. Four studies have been entered into the record. (DX 11, 29; CX 1; EX 1). The April 26, 2005, study produced qualifying resting results, but non-qualifying results after exercise. The other studies were all non-qualifying. *Id.* Therefore, I find that the blood gas study evidence of record does not establish total disability under subsection (b)(2)(ii).

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[13] Maximum voluntary ventilation.

[14] The fact finder must resolve conflicting heights of the miner recorded on the ventilatory study reports in the claim. *Protopappas v. Director, OWCP*, 6 B.L.R. 1-221 (1983). As the three reports show varying heights from 67.7 inches to 69 inches, I will use the average and find the Claimant's height to be 68.4 inches.

[15] Employer submitted the report of Dr. Renn in rebuttal to the November 7, 2002, pulmonary function study conducted by Dr. Sundaram. (EX 3). Dr. Renn invalidated the MVV results, but found the other results acceptable. However, this pulmonary function study produced qualifying results without considering the invalid MVV.

Total disability under § 718.204(b)(2)(iii) is inapplicable because Claimant failed to present evidence of cor pulmonale with right-sided congestive heart failure.

Where total disability cannot be established under subparagraphs (b)(2)(i), (b)(2)(ii) or (b)(2)(iii), § 718.204(b)(2)(iv) provides that total disability may nevertheless be found if a physician exercising reasoned medical judgment, based on medically acceptable clinical and laboratory diagnostic techniques, concludes that a miner's respiratory or pulmonary condition prevents the miner from engaging in his usual coal mine work or comparable gainful work.

All of the physicians of record opine that Claimant is totally disabled due to his pulmonary condition. (DX 11, 27, 29; CX 1; EX 1). All of the physicians based their total disability opinions on objective medical testing, clinical observations, and Claimant's history. *Id.* Thus, I find that the medical reports of record support a finding of total disability. Therefore, Claimant has established total disability pursuant to § 718.204(b)(2)(iv). In sum, I rely on the medical reports, along with the qualifying pulmonary function studies, to find total disability has been established pursuant to § 718.204.

Total Disability Due to Pneumoconiosis:

The regulations state that a claimant "shall be considered totally disabled due to pneumoconiosis if pneumoconiosis ... is a substantially contributing cause of the miner's totally disabling respiratory or pulmonary impairment." § 718.204(c)(1). Pneumoconiosis is considered a "substantially contributing cause" of the claimant's disability if it:

(i) Has a material adverse effect on the miner's respiratory or pulmonary condition; or

(ii) Materially worsens a totally disabling respiratory or pulmonary impairment which is caused by a disease or exposure unrelated to coal mine employment.

§ 718.204(c)(1).

In interpreting this requirement, the United States Court of Appeals for the Sixth Circuit has stated that pneumoconiosis must be more than a *de minimus* or infinitesimal contribution to the miner's total disability. *Peabody Coal Co. v. Smith*, 127 F.3d 504, 506-507 (6th Cir. 1997). Claimant must prove total

disability due to pneumoconiosis as demonstrated by documented and reasoned medical reports. *See* § 718.204(c)(2).

Drs. Forehand and Sundaram both opined that Claimant is totally disabled due to pneumoconiosis. As discussed above, I have found both opinions well-reasoned and well-documented on the issues of legal pneumoconiosis and total disability. As their opinions are based on objective medical testing and their personal evaluations of Claimant and his medical and occupational histories, I also find their opinions well-reasoned on the issue of total disability due to pneumoconiosis.

I have found the reports of Drs. Wicker, Repsher, and Jarboe unreasoned as to the existence of legal pneumoconiosis, for the reasons stated above, while I have found their opinions well-reasoned as to their diagnoses of total disability.

The Board has held that it was proper for an administrative law judge to accord less weight to physicians' opinions, which concluded that pneumoconiosis did not contribute to the miner's disability, on grounds that the physicians did not diagnose pneumoconiosis. *See Osborne v. Clinchfield Coal Co.*, BRB No. 96-1523 BLA (Apr. 30, 1998)(*en banc on recon.*)(unpub.). Accordingly, I find Dr. Wicker's, Dr. Repsher's, and Dr. Jarboe's medical reports unreasoned and give them little weight on the issue of total disability due to pneumoconiosis.

Therefore, I find that Claimant has established total disability due to pneumoconiosis.

Entitlement:

As Claimant has established pneumoconiosis arising out of coal mine employment and total disability due to pneumoconiosis, he is entitled to benefits under the Act.

Date of Entitlement:

Section 725.503 provides that benefits are payable to a miner who is entitled beginning with the month of the onset of total disability due to pneumoconiosis. Where the evidence does not establish the month of onset, benefits shall be payable to the miner beginning with the month during which the claim was filed.

The record in this case does not contain any medical evidence establishing exactly when Claimant became totally

disabled. Therefore, payment of benefits is established as of November 2003, the month and year in which Claimant filed this claim for benefits.

Attorney's Fees:

No award of attorney's fees for service to Claimant is made herein because no application has been received from counsel. A period of thirty (30) days is hereby allowed for the Claimant's counsel to submit an application. *Bankes v. Director,* 8 BLR 2-1 (1985). The application must conform to §§ 725.365 and 725.366, which set forth the criteria on which the request will be considered. The application must be accompanied by a service sheet showing that service has been made upon all parties, including Claimant and Solicitor as counsel for the Director. Parties so served shall have twenty (20) days following receipt of any such application within which to file their objections. Counsel is forbidden by law to charge Claimant any fee in the absence of the approval of such application.

ORDER

It is HEREBY ORDERED that

1. The claim of T. E. for benefits under the Act is hereby GRANTED;

2. Consol of Kentucky, Inc., as insured by Acordia Employers Services, shall pay T. E. all benefits to which he is entitled to under the Act;

3. Consol of Kentucky, Inc., as insured by Acordia Employers Services, shall refund to the Black Lung Disability Trust Fund all benefits, plus interest, if previously paid on behalf of T. E.; and,

4. Consol of Kentucky, Inc., as insured by Acordia Employers Services, shall pay Claimant's attorney, Andrew Delph, fees and expenses to be established in a supplemental decision and order.

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LARRY S. MERCK
Administrative Law Judge

Notice of Appeal Rights: If you are dissatisfied with the administrative law judge's decision, you may file an appeal with the Benefits Review Board ("Board"). To be timely, your appeal must be filed with Board within thirty (30) days from the date of which the administrative law judge's decision is filed with the District Director's office. *See* §§ 725.478 and 725.479. The address of the Board is: Benefits Review Board, U.S. Department of Labor, P.O. Box 37601, Washington, DC 20013-7601. Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. *See* § 802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board.

After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed.

At the time you file an appeal with the Board, you must also send copy of the appeal letter to Allen Feldman, Associate Solicitor, Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Ave., NW, Room N-2117, Washington, DC 20210. *See* § 725.481.

If an appeal is not timely filed with the Board, the administrative law judge's decision becomes the final order of the Secretary of Labor pursuant to § 725.479(a).